McFloop Form

PROGRAM:

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____
Patient Name _____
InSyst # _____

Summary of Recommendations/Requests for Action:

_____

Physician Reviewer Signature & Discipline **Date**

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

_____

Physician Signature & Discipline **Date**

Verification of Physician Response

( ) Approved

( ) Disapproved (Forwarded to PTSOC)

_____

Physician Reviewer Signature & Discipline **Date**